MDR Tracking Number: M5-04-1913-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-26-04.

The IRO reviewed therapeutic procedures and therapeutic procedure – unlisted rendered from 02-28-03 through 07-23-03 that were denied based upon "U".

The IRO determined that all services on date of service 07-23-03 and services for all dates of service in excess of 5 units per DOS **were not** medically necessary, therefore services not exceeding 5 units per DOS with the exception of 07-23-03 **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-05-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code **97139** date of service 03-03-03, code **99213-MP** date of service 05-21-03 and code **97018** date of service 08-13-03. The requestor submitted copies of HCFA's, however, no convincing evidence of carrier receipt was submitted. Per Rule 133.308(f)(2)(3) no reimbursement is recommended.

CPT code **99244** date of service 03-31-03 denied with denial code F (fee guideline MAR reduction). The requestor submitted relevant information to support delivery of service per Rule 133.307(g)(3)(A-F). Reimbursement in the amount of **$148.00** is recommended.

CPT code **99243** date of service 04-25-03 denied with denial code F (fee guideline MAR reduction). The requestor submitted relevant information to support delivery of service per Rule 133.307(g)(3)(A-F). Reimbursement in the amount of **$116.00** is recommended.

CPT code **97110** date of service 08-11-03 denied with denial code F (fee guideline MAR reduction). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 02-28-03 through 04-25-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 14th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 7/8/04

MDR Tracking Number: M5-04-1913-01
IRO Certificate Number: 5259

June 3, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY
The patient received physical medicine treatments after injuring both upper extremities at work on ___ while welding a thick plastic pipe with a hot-air weld gun.

REQUESTED SERVICE(S)
Therapeutic procedure (97110) and therapeutic procedure-unlisted (97139) from 02/28/03 to 07/23/03.

DECISION
All units of therapeutic procedure (97110) and/or therapeutic procedure – unlisted (97139) in excess of 5 per DOS are denied. All units on 7/23/03 are denied.

RATIONALE/BASIS FOR DECISION

No medical records were submitted to support or document the medical necessary for 7 units of therapeutic procedures per DOS. Absent documentation for that extraordinary amount of treatment to the upper extremities, the medical necessity of the additional 2 units per DOS cannot be established. The treatment on 7/23/03 is denied since no documentation was supplied to support the medical necessity of continued therapeutic procedures after an interval of 90 days.